



TRICARE *Beneficiary Handbook*

Your guide to program benefits



Important Information

TriWest Healthcare Alliance:	1-888-TRIWEST (1-888-874-9378)
TriWest Web Address:	www.triwest.com
TRICARE Information Service:	1-888-DoD-CARE (1-888-363-2273)
TRICARE National Web Address:	www.tricare.osd.mil
TRICARE Mail Order Pharmacy (<i>Express-Scripts</i>):	1-866-DoD-TMOP (1-866-363-8667)
TRICARE Retail Pharmacy (<i>Express-Scripts</i>):	1-866-DoD-TRRx (1-866-363-8779)

Your Primary Care Manager:

Other Providers:

Name:

Name:

Name:

Behavioral Health Care Provider:



An Important Note About TRICARE Program Changes

This “TRICARE Beneficiary Handbook” will help you learn about your TRICARE benefits and services. At the time of printing, the information in this booklet is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continuous, and new benefits are added regularly as we continue to make TRICARE a better program for you. For the most recent information, contact your regional contractor, TriWest Healthcare Alliance at 1-888-TRIWEST (1-888-874-9378) or visit them online at www.triwest.com. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can also be found online at www.tricare.osd.mil.



TRICARE: Making a Strong Program Even Better



West Region

1-888-TRIWEST (1-888-874-9378)
www.triwest.com

North Region

1-877-TRICARE (1-877-874-2273)
www.healthnetfederalservices.com

South Region

1-800-444-5445
www.humana-military.com

TRICARE is the Department of Defense (DoD) health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE's primary objectives are to optimize the delivery of health care services in military treatment facilities (MTFs) and attain the highest level of beneficiary satisfaction through the delivery of a world-class health care benefit. TRICARE brings together the health care resources of the Army, Navy, and Air Force and enhances their services with networks of civilian health care professionals.

TRICARE's vision is to provide a world-class health system that meets all wartime and peacetime health care needs for the active duty and retired military and their families. TRICARE is available worldwide to all eligible beneficiaries. The TRICARE program continues to evolve with the ever-changing needs of the uniformed services, both active and reserve components. Each year, improvements are made that make this strong program even better.

TriWest Proudly Serves Its Beneficiaries One at a Time

The DoD has partnered with TriWest Healthcare Alliance to assist in operating the TRICARE program for more than 2.6 million beneficiaries in the TRICARE West Region. The West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner including El Paso only), Utah, Washington, and Wyoming.

TriWest was founded in 1996 with the goal of providing access to locally based, cost-effective health care to TRICARE beneficiaries. TriWest is owned by 15 Blue Cross and Blue Shield plans and two university hospital systems. These same organizations also serve as TriWest's provider network subcontractors. Thus, TriWest has the experience needed to provide outstanding customer service and access to high-quality health care in the areas it serves.

For the past seven years, TriWest has built a strong foundation on providing TRICARE beneficiaries like you with unparalleled customer service, valuable health care programs and services, dependability, and dedication. TriWest is committed to serving you in this manner and to making the transition into the West Region as smooth as possible.

As the TRICARE health service and support contractor for the West Region, TriWest is dedicated to using its time, expertise, and energy to help ensure that you and your family receive the quality of care you deserve in a timely and cost-effective manner. It is TriWest's mission to serve you with the same dedication with which you or your family members serve, or have served, your country. Making good on the promise of TRICARE is our only focus; you can count on TriWest to fulfill that mission.



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Eligibility for TRICARE

TRICARE Choices

TRICARE is available to eligible beneficiaries from any of the seven uniformed services of the United States: the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health

Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). Several program options are available for TRICARE's unique beneficiary population. The chart below lists the options available to you. Each of these programs is described in more detail later in this guide.

Beneficiary Category	Your Options	Enrollment Requirements
Active duty service member (ADSM)	TRICARE Prime	Enroll with your regional contractor and select a primary care manager (PCM).
Active duty family member (ADFM)-Spouses and unmarried children up to age 21 (23 if enrolled in college full time)	TRICARE Prime TRICARE Extra TRICARE Standard	If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider.
Uniformed services retirees under age 65 and eligible family members		
ADSM who lives and works more than 50 miles or an hour drive time from an MTF	TRICARE Prime Remote (TPR)	Enroll with your regional contractor and select a network PCM (if available).
Family members residing with ADSM who lives and works more than 50 miles or an hour drive time from an MTF	TRICARE Prime Remote for Active Duty Family Members (TPRADFM) TRICARE Extra TRICARE Standard	If you choose TPRADFM, enroll with your regional contractor and select a network PCM (if available). If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider.
Member of the Reserve Component on active duty orders (activated)	TRICARE Prime (treated as ADSM) or TPR (if you meet eligibility requirements)	Enroll with your regional contractor and select a PCM.
Family of Reserve Component member activated for 30 days or more	TRICARE Prime TPRADFM TRICARE Extra TRICARE Standard	If you choose TRICARE Prime or TPRADFM, enroll with your regional contractor and select a PCM (if available). If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider.
Medicare-eligible beneficiary under age 65	TRICARE Prime TRICARE Extra TRICARE Standard	Enroll in Medicare Part B (required for all Medicare-eligible beneficiaries except for ADFM under age 65). If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider who accepts Medicare.
Medicare-eligible beneficiary age 65 and over	TRICARE For Life (TFL)	Enroll in Medicare Part B and seek care from any TRICARE-authorized provider who accepts Medicare.
Congressional Medal of Honor recipients and their immediate family members	TRICARE Prime TRICARE Extra TRICARE Standard TFL (if age 65 and over)	If you choose TRICARE Prime, enroll with your regional contractor and select a PCM. If you choose to use TRICARE Extra, locate a TRICARE network provider. To use TRICARE Standard, seek care from any TRICARE-authorized provider. If age 65 and over, enroll in Medicare Part B and seek care from any TRICARE-authorized provider who accepts Medicare.
Certain former spouses of active or retired military service members		

This chart does not list every eligible beneficiary category. To find out if you're eligible for TRICARE, call DEERS at 1-800-538-9552 or visit the TRICARE Web site at www.tricare.osd.mil for a complete list of eligible beneficiary categories.

Updating DEERS

Eligibility for TRICARE is determined by the Defense Enrollment Eligibility Reporting System (DEERS), a database of uniformed services members (sponsors), family members, and others worldwide who are entitled under the law to TRICARE benefits. Active duty and retired service members are automatically registered in DEERS, but it's the sponsor's responsibility to ensure that his or her eligible family members are registered correctly in DEERS. All sponsors should ensure that their family members' status (marriage, divorce, new child, etc.), residential address, telephone numbers, and e-mail address are current in DEERS so that TRICARE can send out information and have claims processed quickly and accurately.

DEERS information may be verified by contacting TriWest at 1-888-TRIWEST (1-888-874-9378) or the nearest uniformed services personnel office (where military identification [ID] cards are issued). Sponsors or registered family members may make address and contact information changes. However, only the sponsor can add or delete a family member from DEERS, and proper documents are required, such as a marriage certificate, divorce decree, and/or birth certificate. Beneficiaries may update their DEERS information in one of the following ways:

- Visit a local uniformed services personnel office. The nearest uniformed services personnel office can be located online at www.dmdc.osd.mil/rsl.
- Call 1-800-538-9552.
- Fax address changes to DEERS at 1-831-655-8317.
- Mail the address change to the Defense Manpower Data Center Support Office
ATTN: COA
400 Gigling Road
Seaside, CA 93955-6771
- Update addresses electronically at www.tricare.osd.mil/DEERSAddress.

If you make any changes to your information in DEERS, please contact TriWest so your most up-to-date information will be on file.

Uniformed Services or Military ID Cards

To use TRICARE benefits, you must have a valid uniformed services or military ID card issued by your service branch and you must be listed in the DEERS database. The ID card states on the back, in the "Medical" block, whether you are eligible for medical care from military or civilian sources. Children under age 10 can normally use the ID card of their parent or guardian, but they must be registered in DEERS. At the age of 10, the child's sponsor should obtain an ID card for the child. Children under 10 should also have an ID card of their own when in the custody of a parent who is not eligible for benefits.

Newborn Enrollment and DEERS

New parents should register newborns in DEERS as soon as possible after birth to ensure continued eligibility for TRICARE. To establish TRICARE eligibility for a newborn in DEERS, parents or legal guardians must submit a certificate of "live birth" from a hospital or TRICARE approved birthing center. They must also provide a copy of a verified and approved DD Form 1172 "Application for Uniformed Services Identification and Privilege Card" signed by the sponsor.

A newborn is covered as a TRICARE Prime beneficiary for the first 120 days after birth—as long as one additional family member is enrolled in TRICARE Prime or TRICARE Prime Remote. After the initial 120 days, any claim submitted for a newborn will process as TRICARE Standard until the infant is enrolled in DEERS and TRICARE Prime, or the infant's TRICARE Standard eligibility ends. Eligibility for TRICARE Standard ends 365 days after birth for any newborn who is not properly registered in DEERS.

TRICARE Program Options

TRICARE's family of programs offers comprehensive health and dental benefits to every TRICARE beneficiary category. It's important to understand the choices available to choose the best option for you and your family.

TRICARE Prime

TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime beneficiaries receive most of their care from a military treatment facility (MTF), supported by the TriWest provider network, and are guaranteed access to care. To enroll in TRICARE Prime, you will complete an enrollment form and select, or will be assigned, a primary care manager (PCM) who provides and coordinates your care, maintains your patient health records, refers you to specialists, and files claims for you. Specialty care must be arranged and approved by your PCM to be covered under TRICARE Prime. TRICARE Prime also offers enhanced coverage for vision, behavioral health, and clinical preventive services. Specialty care received without proper authorization will be covered under the TRICARE Prime point-of-service (POS) option which includes a deductible, higher copayments, and cost-shares.

Eligibility for TRICARE Prime

TRICARE Prime is available to active duty service members, family members, and survivors of active duty personnel; retirees, their family members, and survivors under age 65; and members of the Reserve Component and their families if the sponsor is activated for more than 30 consecutive days. All eligible beneficiaries must be registered in the Defense Enrollment Eligibility Reporting System (DEERS) and reside in a service area where TRICARE Prime is offered.

Enrollment

To participate in TRICARE Prime, you must enroll by completing a TRICARE Prime enrollment form and submitting it to TriWest.

Active duty service members are automatically covered under the TRICARE Prime benefit but are still required to complete an enrollment form. There is no enrollment fee for active duty family members. Retirees and their family members must pay an annual enrollment fee of \$230 for an individual or \$460 for a family to enroll in TRICARE Prime. Payments can be made in annual, quarterly, or monthly installments.

Enrollment in TRICARE Prime is continuous. You may choose to disenroll, or you may be disenrolled due to a move to a non-TRICARE Prime service area or for nonpayment of enrollment fees. If you choose to disenroll from TRICARE Prime before your annual enrollment renewal date, or are disenrolled for nonpayment, you may be subject to a one-year lockout. The lockout provision does not apply to active duty family members of E-1 through E-4. Please note that any change in status (e.g., active duty to retired or demobilization) will cause a disenrollment from TRICARE Prime. When there is a status change you **MUST** re-enroll in TRICARE Prime to maintain your coverage.

TRICARE Prime Access Standards

Another advantage of enrolling in TRICARE Prime is the TRICARE Prime access standards. You are guaranteed an appointment within the following standards:

- The wait time for an urgent care appointment shall not exceed 24 hours.
- The wait time for a routine appointment shall not exceed one week.
- The wait time for a specialty care appointment or wellness visit shall not exceed four weeks.

Additionally, under normal circumstances, your travel time may not exceed 30 minutes from your home to your PCM's office for primary care, and you should not have to travel more than one hour from your home for referred specialty care.

TRICARE Prime Travel Entitlement

If you are referred by your PCM for specialty care at a location more than 100 miles from your PCM, you may be eligible to have your “reasonable travel expenses” reimbursed by TRICARE. You must have a valid referral and travel orders from a TRICARE representative at the MTF where you are enrolled or from the TRICARE Regional Office if your PCM is a TRICARE network provider.

Reasonable travel expenses are the actual costs incurred when traveling such as meals, gas/oil, tolls, parking, and tickets for public transportation (i.e., airplane, train, bus, etc.). You must submit receipts for expenses above \$75. You are expected to use the least costly mode of transportation, and government rates will be used to estimate the reasonable cost. The actual cost of lodging (including taxes and tips) and the actual cost of meals (including taxes and tips, but excluding alcoholic beverages) may be reimbursed up to the government rate for the area concerned.

A parent, guardian, or other adult family member* is authorized to travel with a non-active duty TRICARE Prime-enrolled patient as a non-medical attendant (NMA). If the NMA is not the parent, he or she must be 21 years of age or older. The NMA is not required to be enrolled in TRICARE Prime or to be TRICARE-eligible. The patient, however, must be enrolled in TRICARE Prime.

This entitlement does not apply to expenses incurred by active duty service members or active duty family members residing with their sponsors overseas, which are reimbursed by other travel entitlements. For additional information about the TRICARE Prime travel entitlement and NMA travel entitlement, visit the TRICARE Web site at www.tricare.osd.mil/primetravel.

**By statute, the NMA must be a parent, legal guardian, or other adult family member. If the NMA family member is active duty or a DoD civilian employee authorized by the MTF or TRICARE Regional Office to accompany a non-active duty TRICARE Prime enrollee as an NMA, he or she is entitled to TDY allowances (per diem and mileage), not actual expenses. If the NMA family member is a civilian not employed or affiliated with the DoD, they are authorized reimbursement for actual travel expenses incurred.*

Getting Care While Traveling

For emergencies while traveling away from home, you should dial 911 or go directly to the nearest hospital emergency department. You (or family members on your behalf) should notify your PCM or regional contractor within 24 hours of receiving emergency medical care to allow your doctor the opportunity to arrange for your continuing treatment.

For treatment of a nonemergency medical condition that cannot wait until you return home, you should coordinate with your PCM before seeking care. You may also call TriWest at 1-888-TRIWEST (1-888-874-9378) for assistance in coordinating out-of-area care. If you do not receive a referral from your PCM and an authorization from TriWest for nonemergency care obtained out of area, your care may be covered under the point-of-service (POS) option, which includes a deductible, higher copayments, and cost-shares.

For additional information about enrolling in TRICARE Prime, call TriWest or visit their Web site to learn more about TRICARE Prime or to request a TRICARE Prime Enrollment Package.

TRICARE Extra and TRICARE Standard

TRICARE Extra and TRICARE Standard are available for TRICARE-eligible beneficiaries who are not able to or who choose not to enroll in TRICARE Prime. Active duty service members are not eligible for TRICARE Extra or TRICARE Standard. There is no enrollment required for either option—no annual enrollment fees and no enrollment forms. Beneficiaries are responsible for annual deductibles and cost-shares.

TRICARE Extra is a preferred provider option (PPO). This means you choose a doctor, hospital, or other medical provider within the TriWest provider network to take advantage of lower costs and less paperwork.

Differences between TRICARE Extra and TRICARE Standard

	TRICARE Extra	TRICARE Standard
Provider Type	In network	Not in network, but still an authorized provider
Cost-share after deductibles	15% for active duty families 20% for retirees and their families	20% for active duty families; nonparticipating providers may also “balance bill” up to 15% above the TRICARE allowable charge 25% for retirees and their families; non-participating providers may also “balance bill” up to 15% above the TRICARE allowable charge

TRICARE Standard is a fee-for-service option. With TRICARE Standard, you may seek care from any TRICARE-authorized provider. The chart above shows the main differences between TRICARE Extra and TRICARE Standard.

To locate a medical provider in the network, visit the TRICARE provider directory online at www.tricare.osd.mil/ProviderDirectory.

TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members

TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) provide active duty service members in the United States and their eligible family members with the TRICARE Prime option while they are assigned to remote duty stations (typically more than 50 miles or an hour’s drive time away from the nearest MTF).

Eligibility for TRICARE Prime Remote

The following TRICARE beneficiary categories are eligible for TPR/TPRADFM:

Active Duty Service Members

Active duty service members (ADSMs) under full-time orders with a permanent duty assignment who live and work more than 50 miles or one hour’s drive time from an MTF (in TPR-designated ZIP codes) are required to enroll in TPR. In some cases, where geographic boundaries create undue hardship for travel, service members living closer than 50 miles may be eligible for TPR. Service members may verify their eligibility based on location by visiting the TPR Web site at www.tricare.osd.mil/remote.

Active Duty Family Members

Active duty family members (ADFMs) residing with their TPR-enrolled sponsors are eligible for TPRADFM and must enroll to enjoy the benefit. Family members who are enrolled in TPRADFM may remain enrolled even if the sponsor receives unaccompanied permanent change of station (PCS) orders as long they continue to reside in the same TPR location.

Reserve Component Family Members

Reserve Component (RC) family members are eligible for TPRADFM if their sponsor is activated for more than 30 consecutive days and the family members reside with their sponsor (within a TPR-designated ZIP code) upon activation or effective date of orders. The activated reservist (sponsor) is not required to be eligible for or enrolled in TPR for their family members to be eligible for TPRADFM.

RC family members must enroll in TPRADFM in order to enjoy the benefit. Once enrolled in TPRADFM, family members who continue to reside in the location where they enrolled may remain in TPRADFM for the entire period of the sponsor’s activation, regardless of any changes in the sponsor’s duty location.

Example:

Staff Sergeant (SSG) James Smith of the U.S. Army Reserve lives with his family in Smalltown, Iowa. He receives orders assigning him to his local Reserve unit for 180 days. His family decides to enroll in TPRADFM. Two months later, SSG Smith receives new orders deploying him to an overseas location for six months. There will be no break in his activation and he will mobilize from his unit.

His family continues to reside in Smalltown, Iowa, so they may remain enrolled in TPRADFM. If, however, they decide to move while SSG Smith is overseas, they will not be able to remain enrolled in TPRADFM, even if they move to a different TPR-designated ZIP code area. They will remain eligible for TRICARE Extra or TRICARE Standard. If they move to a location where TRICARE Prime is available, they can enroll in TRICARE Prime.

Enrolling in TPR/TPRADFM

Eligible ADSMs must enroll in TPR and complete an enrollment form. Family members of eligible active duty service members may enroll in TPRADFM or continue to receive care under TRICARE Extra or TRICARE Standard with applicable cost-shares and deductibles. To enroll in TPR and TPRADFM, an enrollment form must be completed and submitted to TriWest.

To see if you reside in a designated TPR service area, visit the TPR Web site at www.tricare.osd.mil/remote. Contact TriWest or visit them online for an enrollment form and a TRICARE Prime Remote Handbook to learn more about how TPR/TPRADFM works.

TRICARE For Life

TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage for TRICARE beneficiaries age 65 and over who become entitled to Medicare Part A and purchase Medicare Part B. TRICARE pays secondary to Medicare beginning on the first day of the month that you turn 65.

Covered Services

- For services covered by both Medicare and TRICARE, Medicare will pay first and TRICARE pays second.
- For services covered by TRICARE but not Medicare, TRICARE will pay its portion and you are responsible for applicable TRICARE deductibles and cost-shares.
- For services covered by Medicare but not TRICARE, Medicare is the only payer, and you are responsible for Medicare cost-shares.

- For services not covered by Medicare or TRICARE, you are responsible for the entire bill.

For services received from a civilian provider, the provider will first file claims with Medicare. Medicare will pay its portion and automatically forward the claim to TRICARE for processing. TRICARE will send its payment for the remaining beneficiary liability directly to the provider. Beneficiaries will receive a Medicare summary notice and a TRICARE explanation of benefits (EOB) indicating the amount paid to the provider. For more information about TFL claims, see the description of claims for dual-eligible beneficiaries in the section entitled, "Your TRICARE Claims."

TRICARE Plus

TRICARE Plus is a primary care enrollment program that is offered at selected MTFs. All beneficiaries eligible for care in MTFs (except those enrolled in TRICARE Prime, a civilian HMO, or Medicare HMO) can seek enrollment for primary care under TRICARE Plus—where it is available. Non-enrollment in TRICARE Plus does not affect TFL benefits or other existing programs. You should contact your local MTF to find out if they participate in TRICARE Plus.

TRICARE Choices for the Reserve Component

Members of the Reserve Component (RC) who are called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any ADSM. Families of these individuals become eligible for TRICARE if the sponsor is called to active duty for more than 30 consecutive days. To ensure family members are eligible for TRICARE upon activation, sponsors must register their family members in DEERS.

Programs Available to the Reserve Component

Family members of the RC become eligible for TRICARE Extra and TRICARE Standard on the first day of the military sponsor's active duty if his or her orders are for more than 30 consecutive days or if the orders are for an indefinite period.

They also become eligible for the TRICARE Pharmacy Program and may have prescriptions filled at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), and at retail network and non-network pharmacies. The TRICARE Pharmacy Program has its own costs separate and apart from all other programs. See the section entitled “What TRICARE Covers” for more information about the pharmacy benefit.

Eligible family members may enroll in TRICARE Prime (or TRICARE Prime Remote if distance eligibility requirements are met) if their sponsor is called to active duty for more than 30 consecutive days. There are no enrollment fees or copayments for family members, but enrollment forms must be completed, and MTFs or network providers must be used if available. Many RC families may have continuing relationships with providers who are not in the TRICARE Prime network. In these cases, enrolling in TRICARE Prime may not be the best choice—instead, using TRICARE Standard can be the most flexible option, even though beneficiaries may be required to pay a share of the cost of health care. If family members are eligible for the TRICARE Reserve Family Demonstration Project (see below), the TRICARE Standard annual deductible will be waived.

TRICARE Reserve Family Demonstration Project

TRICARE Reserve Family Demonstration Project participants are limited to families of Reserve and National Guard members called to active duty for periods of more than 30 consecutive days in support of operations that result from the terrorist attacks of September 11, 2001, under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or 32 U.S.C. 502(f). Such operations include, for example, OPERATIONS ENDURING FREEDOM, NOBLE EAGLE, and IRAQI FREEDOM. TRICARE Reserve Family Demonstration Project components include:

- Waiver of TRICARE Standard annual deductibles
- Waiver of the TRICARE allowable charge under TRICARE Standard

- Waiver of requirement to obtain nonavailability statements for nonemergency inpatient care

Temporary Reserve Health Care Benefits for 2004

The recently enacted Emergency Supplemental Appropriations Act and the National Defense Authorization Act for Fiscal Year 2004 authorized temporary health care benefits for TRICARE eligibility for eligible Reserve Component sponsors and their family members. The TRICARE Management Activity (TMA) is working closely with Reserve Affairs and the uniformed services to implement these temporary benefits for the Reserve Component and their families. Please visit the TRICARE Web site at www.tricare.osd.mil for new information about these temporary benefits as the details are made available. Additionally, information about the new benefits will be highlighted in newsletters, bulletins, and other educational materials in the future.

For additional information about TRICARE benefits available to the Reserve Component, visit the TRICARE Web site at www.tricare.osd.mil.

TRICARE Dental Programs

TRICARE currently offers two dental programs: the TRICARE Dental Program and the TRICARE Retiree Dental Program. These programs are separate from the TRICARE medical program and have their own eligibility criteria and fees.

TRICARE Dental Program

The TRICARE Dental Program (TDP) is a voluntary dental insurance program administered by United Concordia Companies, Inc. (UCCI). TDP is available to eligible active duty family members, Selected Reserve and Individual Ready Reserve (IRR) members, and their eligible family members. Active duty personnel (and Reservists called to active duty for a period of more than 30 consecutive days) are not eligible for TDP. They receive dental care from military dental treatment facilities. Former spouses, parents, parents-in-law, disabled veterans,

foreign military personnel, and uniformed services retirees and their families are not eligible for TDP. Other details of TDP benefits, requirements, and restrictions can be found at the UCCI Web site at www.ucci.com/was/ucciweb/home.jsp.

TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) is a voluntary dental insurance program administered by the Federal Services division of Delta Dental Plan (DDP) of California. TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. Other details of TRDP benefits, requirements, and restrictions can be found at the DDP Web site at www.trdp.org.

Uniformed Services Family Health Plan

The Uniformed Services Family Health Plan (USFHP) is an extra TRICARE Prime option available to families of active duty military, retirees, and their eligible family members, including those age 65 and over, through networks of community-based hospitals and physicians in six areas of the country.

With roots as Uniformed Services Treatment Facilities (USTFs), the USFHP has been a part of the Military Health System for 22 years. Since the DoD reorganized the USTFs in 1993, the USFHP has remained a managed care plan offering all of the health care coverage and benefits, plus some additional enhancements, at the same costs as TRICARE Prime.

When enrolled in the USFHP, members do not access Medicare or MTFs, but instead receive their care from a primary care physician selected by the beneficiary from a network of private physicians affiliated with one of the not-for-profit health care systems offering the plan. That primary care physician assists the member in getting appointments for specialists in the area and coordinates care. Members are covered for

worldwide emergency care and many preventive care services. They can access on-site patient advocates for assistance, and they enjoy enhancements in some areas, including discounts for eyeglasses, hearing aids, and dental care.

Enrollment in the USFHP

To enroll in the USFHP, you must submit a completed application to the USFHP program of choice. Enrollees must reside in one of the service areas listed below. All eligible beneficiaries may enroll at anytime throughout the year, however, beneficiaries make a one year commitment to receive their care from the plan, unless they move out of the area where the plan is offered. Enrollment fees, if applicable, are portable to another TRICARE Prime program.

USFHP enrollment is offered through:

Johns Hopkins Community Physicians 1-800-808-7347

Serving central Maryland and parts of Pennsylvania, Virginia, and West Virginia

Martin's Point Health Care 1-888-241-4556

Serving Maine and New Hampshire

Brighton Marine Health Center 1-800-818-8589

Serving central and eastern Massachusetts, including Cape Cod, and Rhode Island

Saint Vincent Catholic Medical Centers 1-800-241-4848

Serving parts of New York, all of New Jersey, eastern Pennsylvania, and southern Connecticut

Christus Health 1-800-678-7347

Serving southeast Texas and southwest Louisiana

Pacific Medical Centers (PacMed Clinics) 1-888-958-7347

Serving the Puget Sound area of Washington State

For more information, visit the US Family Health Plan Web site at www.usfamilyhealthplan.org.

TRICARE Overseas

The TRICARE Overseas Program (TOP) is the DoD's managed health care program for all geographic areas and territorial waters outside the 50 United States. TOP blends many of the features of the stateside TRICARE programs while also allowing for the significant cultural differences unique to foreign countries and their health care practices.

The TOP consists of three overseas regions: TRICARE Europe, TRICARE Pacific, and TRICARE Latin America and Canada, which includes the Caribbean Basin. Unlike the three regions in the United States—TRICARE North, TRICARE South, and TRICARE West—the overseas regions are managed by overseas regional directors.

Although TRICARE beneficiaries residing overseas are entitled to the same benefits as those living stateside, several differences in the availability of options exist because of the geographical differences. The benefit packages listed below are available overseas:

TOP Prime—Offers TRICARE Prime benefits to active duty service members and their eligible family members residing with their sponsor overseas. There are no enrollment fees, cost-shares, or deductibles for TOP Prime enrollees.

TOP Standard—Identical to the stateside program, including cost-shares and deductibles. Active duty family members living overseas may choose between TOP Prime and TOP Standard. Retirees and their families who live overseas cannot enroll in TOP Prime but are covered under TOP Standard.

TOP TRICARE For Life (TFL)—Available to all beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B. Because Medicare does not provide benefits for medical care received overseas, TFL coverage is similar to TRICARE Standard overseas.

TRICARE Global Remote Overseas—Provides access to the TRICARE Prime benefit to active duty service members and family

members who are assigned to designated duty stations in remote overseas locations where MTFs are not available. Active duty service members and their families must enroll to a designated remote overseas location.

Overseas Pharmacy Services—You may have prescriptions filled at MTF pharmacies in all overseas locations, if the medication is available on the MTF's formulary. TRICARE Mail Order Pharmacy (TMOP) may be used if you have an APO or FPO address or a state department mail pouch for pharmacy. The prescription must be written by a U.S. licensed provider. Drugs purchased by TOP eligible beneficiaries at overseas embassies may not be covered under TRICARE. The TRICARE retail network pharmacy benefit is available overseas only in Puerto Rico, the Virgin Islands, and Guam.

The TRICARE Dental Program (TDP) is also available overseas. For more information about TRICARE benefits available overseas, call 1-888-777-8343. All overseas regions may be reached via this telephone number. You may also visit the TRICARE Web site at www.tricare.osd.mil/overseas for more information.

Program for Persons with Disabilities

The Program for Persons with Disabilities (PFPWD) will be replaced by the Extended Care Health Option (ECHO) in regional phases over the course of the year 2004. The following information regarding PFPWD pertains to areas where ECHO has not yet become effective.

PFPWD is designed to provide financial assistance to family members of active duty service members in order to treat and/or reduce the effects of mental retardation or serious physical disability. PFPWD is not a stand-alone program and has no enrollment; subject to certain restrictions, it may be used concurrently with other TRICARE medical programs. The PFPWD serves persons with two types of serious disabilities: moderate or severe mental retardation and/or significant physical disability.

The monthly cost-share amount for the PFPWD varies from \$25 to \$250, depending on the active duty sponsor's rank. PFPWD allowable amounts are not subject to a deductible. The maximum monthly program payment for PFPWD benefits is \$1,000. The sponsor is responsible for the appropriate cost-share amount plus any amount in excess of the maximum monthly coverage.

To find out if you or a family member qualifies for PFPWD, contact TriWest at 1-888-TRIWEST(1-888-874-9378).

Transitional Health Care Benefits

TRICARE offers options for those beneficiaries who are separating from active duty. These options are described below.

Transitional Assistance Management Program

Through the Transitional Assistance Management Program (TAMP), certain uniformed services members and their family members may be eligible for transitional health care benefits when the sponsor separates from active duty service. Service member categories include:

- A member who is involuntarily separated from active duty if under honorable conditions
- A Reserve Component member who is separated from active duty and who was called up or ordered in support of a contingency operation for an active duty period of more than 30 consecutive days
- A member who is separated from active duty and is involuntarily retained in support of a contingency operation
- A member who is separated from active duty following a voluntary agreement to stay on active duty for a period of less than one year in support of a contingency mission

Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is intended to provide transitional benefits for a specified period of time (18–36



months) to former service members and their families, some un-remarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums. The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. The quarterly premiums for the coverage are \$933 for one person and \$1,996 for a family. To receive coverage under CHCBP, eligible persons must enroll by completing a CHCBP application within 60 days after separating from active duty or losing their eligibility for TRICARE. The DoD has contracted with Humana Military Healthcare Services, Inc. (HMHS) to administer CHCBP. Beneficiaries may contact HMHS in writing or by phone for any information regarding CHCBP at the following address or phone number:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40202
1-800-444-5445

Voluntary Separation Benefits

Service members voluntarily separated under the Special Separation Benefit (SSB) or the Voluntary Separation Incentive (VSI) are entitled to all benefits provided to involuntarily separated members. Members who choose SSB or VSI (and their families) may receive health benefits by enrolling in CHCBP.

What TRICARE Covers

TRICARE covers most inpatient and outpatient care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. Some military treatment facilities (MTFs) may offer services, procedures, or benefits that are not necessarily covered under TRICARE. You should contact your local MTF for more information. To find an MTF near you, visit the MTF Locator on the TRICARE Web site at www.tricare.osd.mil/mtf or visit the TriWest MTF directory at www.triwest.com.

A prior authorization is a process of reviewing medical, surgical, and behavioral health services to ensure medical or psychological necessity and appropriateness of care prior to services being rendered. You or your provider must notify TriWest to obtain a prior authorization. For a complete list of services and/or procedures requiring prior authorization, contact TriWest at 1-888-TRIWEST (1-888-874-9378).

To find additional information about services covered by TRICARE, contact TriWest, visit their Web site, or visit the TRICARE Web site at www.tricare.osd.mil.

Emergency and Urgent Care

Urgent Care

Urgent care services are medically necessary services which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat or rising temperature.

Emergency Services

TRICARE defines an emergency as a medical, maternity, or psychiatric emergency that would lead a “prudent layperson” (someone with average knowledge of health and medicine) to believe that a serious medical condition existed, or the absence of medical attention would result in a threat to his/her life, limb, or sight, and

requires immediate medical treatment, or which has painful symptoms requiring immediate attention to relieve suffering. This includes situations where a beneficiary presents with severe pain.

In the event of a life-, limb-, or eyesight-threatening emergency, you should go, or be taken to, the nearest emergency department for care. In all emergency situations, you must notify your primary care manager (PCM) or regional contractor within 24 hours of any emergency admission so that ongoing care can be coordinated (if enrolled in TRICARE Prime).

Medical and Surgical Covered Services

The following charts summarize TRICARE-covered services. Any covered services obtained at an MTF are at no cost to you. Please note that TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) offer coverage similar to TRICARE Prime, and if enrolled, you are not responsible for deductibles, cost-shares, or copayments. However, for active duty family members (ADFM), the waiver of copayments, cost-shares, and deductibles does not apply to pharmacy copayments, Program for Persons with Disabilities (PPPWD) cost-shares, or TRICARE Prime point-of-service (POS) cost-shares and deductibles. See the section entitled “Costs and Fees” for information about the TRICARE Prime POS option. For more information about pharmacy copayments, see the description of the TRICARE Pharmacy Program later in this section.

For the services listed in these charts, TRICARE has established catastrophic caps (cat caps). Cat caps act as built-in safety nets to limit beneficiaries’ out-of-pocket expenses on TRICARE-covered medical bills. In order to get medical costs credited towards cat caps, the beneficiary may be required to provide proof of medical care, such as an explanation of benefits (EOB). Please see the section entitled “Understanding TRICARE Costs and Fees” for information about catastrophic caps.

Outpatient Services Outside of an MTF

Outpatient services received in an MTF are at no cost to the beneficiary. For the charts on the following pages, “ADFM” is the active duty family member responsibility.

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Ancillary Services Certain diagnostic radiology and ultrasound (70000-76999); diagnostic nuclear medicine (78000-78999); pathology and laboratory services (80000-89399); and cardiovascular studies (93000-93350)	Per visit: ADFM: No copayment Retirees and others: No copayment	ADFM: 15% of contracted reimbursement Retirees and others: 20% of contracted reimbursement	ADFM: 20% of the maximum allowable charge Retirees and others: 25% of the maximum allowable charge
Ambulance Services When medically necessary and when needed for a medical condition that is covered by TRICARE	Per occurrence: ADFM: No copayment Retirees and others: \$20 copayment	<i>Same as above</i>	<i>Same as above</i>
Ambulatory Surgery (Same Day)⁽¹⁾ When surgery is conducted at a hospital-based or freestanding ambulatory surgical center that is TRICARE-certified TRICARE Prime Retirees and others—copayment is applied to the ambulatory surgical facility only.	Per occurrence: ADFM: No copayment Retirees and others: \$25 copayment	ADFM: \$25 copayment Retirees and others: Professional—20% of contracted reimbursement Facility—20% of contracted reimbursement	ADFM: \$25 copayment Retirees and others: Professional—25% of the maximum allowable charge Facility—25% of the group rate or 25% of billed charges; whichever is less
Durable Medical Equipment (DME), Prosthetic Devices and Medical Supplies (Prescribed by a Physician)⁽¹⁾⁽³⁾ For DME, prosthetic devices, and medical supplies, care is subject to TRICARE policy after an office or home health visit when medically necessary and a covered benefit.	ADFM: No copayment Retirees and others: 20% of contracted reimbursement	ADFM: 15% of contracted reimbursement Retirees and others: 20% of contracted reimbursement	ADFM: 20% of the maximum allowable charge Retirees and others: 25% of the maximum allowable charge
Emergency Services⁽¹⁾ Emergency care obtained on an outpatient basis, both network and non-network, in or out of the region.	Per visit: ADFM: No copayment Retirees and others: \$30 copayment	<i>Same as above</i>	<i>Same as above</i>

*Cost-share is applied after deductible has been satisfied.

**Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.

1. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.
2. If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.
3. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Outpatient Services Outside of an MTF (continued)

Services Covered	TRICARE Prime**	TRICARE Extra*	TRICARE Standard*
Eye Examinations One routine examination per year for active duty family members. For additional coverage, see “Eye Examinations” under Clinical Preventive Services Benefits.	ADFM: No copayment Retirees and others: Not covered	ADFM: 15% of contracted reimbursement Retirees and others: Not covered	ADFM: 20% of the maximum allowable charge Retirees and others: Not covered
Home Health Care⁽³⁾ Same as the Medicare home health care benefit, providing a maximum of 28 hours per week part time, or 35 hours per week intermittent, skilled nursing care and physical, speech, and occupational therapy. All care must be provided by a participating home health care agency.	Per visit: ADFM: No copayment Retirees and others: \$12 copayment	ADFM: 15% of contracted reimbursement Retirees and others: 20% of contracted reimbursement	<i>Does not apply</i>
Individual Provider Services⁽¹⁾ Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; medical supplies used within the office, including casts, dressings, and splints.	Per visit: ADFM: No copayment Retirees and others: \$12 copayment	<i>Same as above</i>	ADFM: 20% of the maximum allowable charge Retirees and others: 25% of the maximum allowable charge
Immunizations for Required Overseas Travel Immunizations required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations.	Per Visit: ADFM: No copayment Retirees and others: Not covered	ADFM: 15% of contracted reimbursement Retirees and others: Not covered	ADFM: 20% of the maximum allowable charge Retirees and others: Not covered
Laboratory and X-Ray Services (provided as part of an office visit)⁽¹⁾⁽²⁾ TRICARE Prime Retirees and others do not have an additional copayment if these services are provided as part of an office visit.	Per visit: ADFM: No copayment Retirees and others: \$12 copayment	ADFM: 15% of contracted reimbursement Retirees and others: 20% of contracted reimbursement	ADFM: 20% of the maximum allowable charge Retirees and others: 25% of the maximum allowable charge

*Cost-share is applied after deductible has been satisfied.

**Benefits under TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) are similar to TRICARE Prime.

1. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.
2. If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.
3. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Inpatient Services (Both MTF and Civilian Facility)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Hospitalization⁽¹⁾⁽²⁾⁽³⁾⁽⁴⁾ Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and surgical services; meals (including special diets); drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. Unlimited services, as medically necessary.	ADFM: MTF: No copayment Civilian: No copayment Retirees and others: MTF: \$13.32 per day Civilian: \$11 per day or \$25 minimum charge per admission, whichever is greater. (No separate copayment for separately billed professional charges. Catastrophic Cap protection limits do apply.)	ADFM: MTF: \$13.32 per day Civilian: \$13.32 per day or \$25 minimum charge per admission, whichever is greater. Retirees and others: MTF: \$13.32 per day Civilian: \$250 per day or 25% cost-share of the total contracted reimbursement for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges based on the contracted reimbursement.	ADFM: MTF: \$13.32 per day Civilian care: \$13.32 per day or \$25 minimum charge per admission, whichever is greater. Retirees and others: MTF: \$13.32 per day Civilian: \$441 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.
Maternity⁽¹⁾⁽²⁾⁽⁴⁾ Hospital and professional services (prenatal, postnatal). Unlimited services, as medically necessary.	<i>Same as above</i>	<i>Same as above</i>	<i>Same as above</i>
Skilled Nursing Facility (SNF) Care⁽¹⁾⁽⁴⁾ Semiprivate room; regular nursing services; meals including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlimited services, as medically necessary.	<i>Same as above</i>	<i>Same as above</i> Except 20% cost-share of the total contracted reimbursement	ADFM: \$25 per admission or \$13.32 per day, whichever is greater. Retirees and others: 25% cost-share of billed charges, plus 25% cost-share of the maximum allowable charge for separately billed professional charges.

*Benefits under TPR and TPRADFM are similar to TRICARE Prime.

1. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).
2. TRICARE Standard beneficiaries may pay up to 15 percent above the maximum allowable charge when the provider does not accept assignment (balance billing). See the Glossary for a description of balance billing.
3. TRICARE Standard cost-share for retirees may vary depending on type of treatment or type of hospital.
4. Requires prior authorization for TRICARE Prime, TPR, and TPRADFM.

Hospice Care

Hospice care is available, in lieu of other TRICARE benefits, to provide palliative care to individuals with prognoses of less than six months to live if the terminal illness runs its normal course. Hospice care must be provided by a Medicare-approved program and may include: physician services, nursing care, counseling, inpatient respite care, medical

supplies, medications, medical social services, home health aide services, physical and occupational services, speech and language pathology, and short-term acute patient care related to terminal diagnosis.

Note: The individual hospice may charge a cost-share for medications, biologicals, and/or inpatient respite care.

Clinical Preventive Services

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
<p>Clinical Preventive Examinations Comprehensive-health-promotion and disease-prevention exams for ages 24 months and older.</p> <p>Examinations can include: blood pressure tests; clinical breast exams (high-risk women age 39 and under; annually for all women over 40); pelvic exams (same guideline as Pap smears and should be administered during same visit); clinical testicular exams (annually for high-risk men 13-39); digital rectal exams (annually for high-risk men 40-49; and all men over 50); Prostate Specific Antigen (annually for high-risk men 40-49; men with history of vasectomy at least 20 years previous or at age 40 and over; and all men over 50); oral cavity exams; thyroid palpations; school enrollment physicals ages 5-11 years.</p> <p><i>Note: Annual sports physicals are not a covered benefit under TRICARE.</i></p>	<p>No copayment</p> <p><i>Clinical preventive services are an enhanced benefit under TRICARE Prime.</i></p>	<p>Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.</p>	<p>Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.</p>
<p>Eye Examinations Clinical preventive service eye exams vary by TRICARE program option (see columns for details of coverage for children and adults).</p> <p><i>Note: In addition to the clinical preventive service eye exams, ADFMs can receive annual eye exams under normal TRICARE outpatient benefits.</i></p> <p>Except for active duty service members (ADSMs), lenses or eyeglasses are only cost-shared for treatment of infantile glaucoma, keratoconus, dry eyes, and irregularities in the shape of the eye.</p>	<p>For Infants: No copayment</p> <ul style="list-style-type: none"> One eye and vision screening by the beneficiary's PCM during routine exam at birth and 6 months of age. Exam to include screening for visual acuity, ocular alignment, and red reflex along with external examination for ocular abnormalities. <p>For Adults and Children Age 3 and over: No copayment</p> <ul style="list-style-type: none"> One comprehensive eye exam by a specialist (ophthalmologist or optometrist) including screening for visual acuity and glaucoma every two years. Diabetic patients at any age are covered for one comprehensive eye exam yearly. 	<p>For Children: Covered under Well-Child Care benefit. Applicable cost-share and deductible apply.</p> <ul style="list-style-type: none"> One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. <p>For Adults: Not covered</p>	<p>For Children: Covered under Well-Child Care benefit. Applicable cost-share and deductible apply.</p> <ul style="list-style-type: none"> One eye and vision screening by a TRICARE network provider during routine exam at birth and 6 months of age. Two comprehensive eye exams by specialist (ophthalmologist or optometrist) for amblyopia (vision loss) and strabismus (cross eye) between 3-6 years of age. <p>For Adults: Not covered</p>

*TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
Immunizations Age appropriate doses of vaccines recommended and adopted by the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). Refer to CDC's homepage (www.cdc.gov) for a current schedule of recommended vaccines. <i>Immunizations for Overseas Travel: See information listed in the Outpatient Services Outside of the MTF section of these charts.</i>	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Patient and Parent Education or Counseling Services The following education or counseling services are covered when included as part of an office visit: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; accident and injury prevention; promoting dental health; stress, bereavement, and suicide risk assessment.	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.
Periodic Screening Examinations Beneficiaries will be offered age- and gender-appropriate screening tests for the early detection of disease and/or disease risk factors, including: Cancer Screening: Annual screening mammograms for women over the age of 39, (for high-risk baseline at 35 years, then annually); Pap smears (see below); proctosigmoidoscopy or sigmoidoscopy (once every 3-5 years beginning at age 50); colonoscopy (every 2 years beginning at age 25 or 5 years younger than the earliest age of diagnosis for colon rectal cancer, whichever is earlier, and then annually after age 40 for individuals with hereditary non-polyposis colon rectal cancer syndrome. Individuals with familial risk of sporadic colon rectal cancer (i.e. individuals with first degree relatives with sporadic colon rectal cancer or adenomas before the age of 60 or multiple first degree relatives with colon rectal cancer or adenomas) may receive a colonoscopy every 3 to 5 years beginning at age 10 years earlier than the youngest affected relative), and fecal occult blood testing (annually age 50 and above); skin cancer exams (for high-risk individuals with family history or increased exposure to sunlight)	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

*TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.

Clinical Preventive Services (continued)

Services Covered	TRICARE Prime*	TRICARE Extra	TRICARE Standard
<p>Routine Pap Smears: Annually starting at age 18 (or younger if sexually active) until three consecutive satisfactorily normal annual examinations. Frequency may be less often at the discretion of the patient and the clinician, but not less than every three years.</p> <p>Infectious Disease Screening: Screening for Hepatitis B, Rubella antibodies, and HIV and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, Hepatitis A&B, meningococcal meningitis, and tuberculosis</p> <p>Cardiovascular: Cholesterol (once every 5 years beginning at age 18) and blood pressure (children: annually between ages 3-6 and every 2 years thereafter; adults: minimum every 2 years)</p> <p>Hearing: Preventive hearing screenings for all high risk neonates as defined by the Joint Committee on Infant Hearing. A newborn audiology screening should be performed on high-risk newborns prior to hospital discharge or within the first three months. Evaluative hearing tests may be performed at other ages during routine exams.</p> <p>Other: Assessment of risk for lead exposure by structured questionnaire (during each Well-Child Care visit from 6 months to 6 years); blood lead test for all children determined to be high-risk</p>	No copayment	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.	Applicable cost-share and deductible apply when service is included as part of a cancer screening visit.
<p>Well-Child Care Well-Child Care (birth to 6 years) includes routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference; routine immunizations; and developmental and behavioral appraisal in accordance with the American Academy of Pediatrics (AAP) and CDC guidelines.</p>	No copayment	Applicable cost-share and deductible apply.	Applicable cost-share and deductible apply.

*TRICARE Prime beneficiaries may receive clinical preventive services from any network provider without a referral or pre-authorization.

Hepatitis B Screening and Vaccines

For Hepatitis B Surface Antigen (HBsAg):

- Screenings for pregnant women during prenatal period
- Infants born to HBsAg-negative mothers receive Hepatitis B vaccine as recommended by the American Academy of Pediatrics (AAP)
- Infants born to HBsAg-positive mothers receive Hepatitis B Immune Globulin (HBIG) as recommended by the AAP

High-risk adults and children receive Hepatitis B vaccine as recommended by the Center for Disease Control Advisory Committee on Immunization Practices. There is no copayment for TRICARE Prime. Applicable cost-share and deductible apply for TRICARE Extra and TRICARE Standard when the service is included as part of a cancer screening visit.

Maternity Care

TRICARE helps pay for maternity care during pregnancy, delivery of the baby, and up to six weeks after the baby is born. Prenatal care is important, and TRICARE strongly recommends that those who are pregnant, or who anticipate becoming pregnant, seek appropriate medical care. If TRICARE eligibility ends during the pregnancy (for example, due to discharge of sponsor), TRICARE does not cover any remaining maternity care unless the family qualifies for the Transitional Assistance Management Program (TAMP) or has enrolled in the Continued Health Care Benefits Program (CHCBP).



Family-centered Care

The new family-centered care program offers families services starting with the first obstetric (OB) visit and continuing after the birth of the child. In creating the family-centered care program, the military services combine their expertise to offer patients a world-class OB benefit while upholding the military's unique ability to assist family members whose sponsors are deployed. Family-centered care gives you:

- Respect for your emotional well-being, privacy, and personal preferences
- Empowerment through honoring your family's personal and cultural beliefs
- Choices in treatment, including pain management, drugs, and tests used before, during, and after childbirth and newborn care
- Flexibility to welcome fathers, significant others, and siblings to be a part of your childbirth experience

Your local MTFs are committed to being responsive to your needs and have implemented several initiatives that include:

- Improved continuity of providers for prenatal care
- Careful, seamless coordination between facilities if you need to relocate during your pregnancy
- Personalized pain management
- Individualized birth plans
- Improved access to first trimester appointments
- Individualized prenatal education
- Private postpartum rooms
- Lactation education and support

Some facilities have even instituted “stork parking” and allow you to schedule follow up appointments before you leave the clinic. Before checking into the civilian network for maternity care and delivery options, we encourage you to visit your local MTF. Military facilities offer an extended “family” who understand the uniqueness of military life.

Behavioral Health Care Services

ADFM represents the active duty family member responsibility.

Services Covered	TRICARE Prime	TRICARE Extra	TRICARE Standard
Outpatient Behavioral Health⁽¹⁾⁽⁵⁾ Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral, or group sessions.	<u>Individual & Family Therapy:</u> ADFM: No copayment Retirees and others: \$25 copayment <u>Group Therapy:</u> ADFM: No copayment Retirees and others: \$17 copayment	Cost-share after deductible has been satisfied: ADFM: 15% of contracted reimbursement Retirees and others: 20% of contracted reimbursement	Cost-share after deductible has been satisfied: ADFM: 20% of the TRICARE allowed amount Retirees and others: 25% of the TRICARE allowed amount
Medication Management No prior authorization is required. (CPT code 90862)	ADFM: No copayment Retirees and others: \$12 copayment	<i>Same as above</i>	<i>Same as above</i>
Hospitalization for Mental Illness⁽¹⁾⁽²⁾⁽³⁾⁽⁴⁾ Up to 30 days per fiscal year (October 1–September 30) for age 19 and over; up to 45 days per fiscal year for age 18 and under. The Residential Treatment Center benefit is up to 150 days per fiscal year for children and adolescents (as medically or psychologically necessary).	ADFM: No copayment Retirees and others: \$40 per day (No copayment for separately billed professional charges.)	ADFM: \$20 per day (\$25 minimum charge) Retirees and others: 20% cost-share of contracted reimbursement for institutional services, plus 20% cost-share of separately billed professional charges, based on contracted reimbursement.	ADFM: \$20 per day (\$25 minimum charge) Retirees and others: 25% cost-share of allowable charges for separately billed professional charges, plus, one of the following: <u>Inpatient High Volume Hospital:</u> 25% hospital specific per diem <u>Inpatient Low Volume Hospital:</u> Lower of fixed daily amount or 25% hospital billed charges <u>RTC:</u> 25% of the TRICARE allowed amount <u>Partial Hospitalization:</u> 25% of the TRICARE allowed amount
Substance Use Treatment (Inpatient Partial Hospital Program)⁽¹⁾⁽²⁾⁽³⁾⁽⁴⁾ Up to seven days for detoxification and up to 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward inpatient day limit.	<i>Same as above</i>	<i>Same as above</i>	<i>Same as above</i>
Partial Hospitalization – Mental Illness⁽¹⁾⁽²⁾⁽³⁾ Up to 60 days per fiscal year (October 1–September 30). Minimum of three hours per day, five days per week of therapeutic services.	<i>Same as above</i>	<i>Same as above</i>	<i>Same as above</i>

1. Requires prior authorization.
2. TRICARE Standard beneficiaries may have to pay up to 15 percent over the maximum allowable charge when the provider does not accept assignment (balance billing). Treatment must be provided by TRICARE-authorized institutional providers.
3. Cost-share and daily inpatient charges are subject to change at the beginning of each fiscal year (October 1–September 30).
4. NAS Note: A nonavailability statement (NAS) is required for all nonemergency inpatient admissions with TRICARE Extra and TRICARE Standard. This does not apply to admissions to RTC, PHP, and SUDRF facilities.
5. All services provided by Pastoral Counselors or Licensed Professional Counselors (LPCs) must be referred and supervised by a physician (M.D. or D.O.).

Getting Behavioral Health Care

You are encouraged to receive behavioral health care from an MTF. However, access may be limited due to space-availability issues or the MTF's ability to render the care needed. When a service is not available at an MTF, you may seek behavioral health care from a network provider. Before you do, please check with your primary care manager or TriWest to make sure you have all required referrals and authorizations. This will ensure you receive the correct benefit payment.

TRICARE Pharmacy Program

TRICARE provides a world-class pharmacy benefit. TRICARE beneficiaries, including Medicare-eligible beneficiaries age 65 and over, are eligible for the TRICARE Pharmacy Program, and can fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), and at retail network and non-network pharmacies. To have a prescription filled, you will need a written prescription and a valid uniformed services ID card. If you are Medicare-eligible and turned age 65 on April 1, 2001, or later, you must be enrolled in Medicare Part B.

Generic Drug Use Policy

It is DoD's policy to substitute generic medications for brand-name medications when available. Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand-name drug in place of the generic equivalent. If a generic equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment.

Drug/Medication Coverage

The DoD Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means that DoD will pay only for up to a specified quantity per 30-, 60-, or 90-day supply. Quantity limits are applied to address the problem of overuse of medications that can be unsafe for you and costly to the government. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity. Additionally,

some drugs require prior authorization. For a general list of prescription drugs that are covered under TRICARE and for drugs requiring prior authorization or quantity limits at TRICARE retail network pharmacies, visit www.express-scripts.com/TRICARE or call toll-free 1-866-DoD-TRRx (1-866-363-8779).

TRICARE Pharmacy Options

MTF Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy free of charge. Each facility is required to make available the medications listed in the DoD basic core formulary. The MTF may add additional medications to its local formulary based on the scope of care at that MTF. Beneficiaries should contact their local MTF for specific details about filling and refilling prescriptions at its pharmacy. MTF pharmacies will accept written prescriptions from any TRICARE-authorized provider.

TRICARE Mail Order Pharmacy

The TRICARE Mail Order Pharmacy (TMOP) is available for prescriptions that you take on a regular basis. You may receive up to a 90-day supply for most medications. TMOP is administered by Express Scripts, Inc. TMOP allows you to mail your written prescription, along with the appropriate copay to TMOP, and the medications will be sent directly to you. Prescriptions may be refilled by mail, phone, or online. For more information about how to use TMOP, visit the TRICARE Web site at www.tricare.osd.mil/pharmacy/tmop.cfm or contact TMOP member services toll-free at 1-866-DoD-TMOP (1-866-363-8667) within the U.S., or 1-866-ASK-4PEC (1-866-275-4732) outside the U.S. You may also visit the Express Scripts Web site at www.express-scripts.com/TRICARE.

TRICARE Retail Pharmacy Network

You may have prescriptions filled at any civilian retail network pharmacy for a small copayment. The TRICARE Retail Pharmacy Network is administered by Express Scripts, Inc. For more information, or to locate a TRICARE network pharmacy near you, contact Express Scripts at www.express-scripts.com/TRICARE or 1-866-DoD-TRRx (1-866-363-8779).

Non-network Pharmacies

Filling prescriptions at a non-network pharmacy is the most expensive option and is not recommended. You may have to pay for the total amount first and file a claim to receive a partial reimbursement.

Pharmacy Copayments

Place of Service	Generic	Brand Name
MTF Pharmacy	\$0	\$0
TMOP (up to a 90-day supply)	\$3	\$9
Retail Network Pharmacy (up to a 30-day supply)	\$3	\$9
Non-network Pharmacy	1. \$9 or 20% of total cost (whichever is greater) 2. Existing deductibles and point-of-service* (POS) penalty apply: E-4 and below, TRICARE Standard, \$50 per person/\$100 per family; E-5 and above, TRICARE Standard, \$150 per person/\$300 per family; TRICARE Prime, \$300 per person/\$600 per family, POS penalty–50%.	

**Please see the description of point-of-service (POS) in the section entitled, "Understanding TRICARE Costs and Fees."*



Pharmacy Data Transaction Service

The Pharmacy Data Transaction Service (PDTS) creates a global centralized data repository that records information about prescriptions filled for TRICARE beneficiaries at MTFs, the TRICARE retail pharmacy network, and through TMOP. PDTS improves the quality of prescription services and enhances patient safety by conducting an online clinical screening against your complete medication history for each new or refilled prescription in real-time before it is dispensed.

Limitations and Exclusions



Below you will find a list of medical, surgical, and behavioral health care services generally not covered under TRICARE. The items here are not intended to be all-inclusive. To contact TriWest, visit their Web site at www.triwest.com, or visit the TRICARE Web site at www.tricare.osd.mil for more information.

Services or Procedures with Significant Limitations

Abortions—Abortions are only covered when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.

Cardiac and Pulmonary Rehabilitation—Both are only covered for non-hospital based cardiac rehabilitation programs and phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically supervised settings.

Chiropractic Care—Coverage is limited to active duty service members and is only available at specific military treatment facilities under the Chiropractic Care Program. Visit the TRICARE Web site at www.tricare.osd.mil/chiropractic for more information.

Cosmetic, Plastic, or Reconstructive Surgery—Only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement, or after a medically necessary mastectomy.

Cranial Orthotic Device or Molding Helmet—Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly.

Dental Care and Dental X-Rays—Both are covered only for adjunctive dental care.

Dental Anesthesia and Facility Charges—

Covered only to safeguard a patient's life.

Education and Training—

Education and training may be covered under the PFPWD. Outpatient diabetic self-management and training programs are covered when the services are provided by a TRICARE authorized individual provider who also meets national standards for diabetes self-management education programs recognized by the American Diabetes Association (ADA). The provider's "Certificate of Recognition" from the ADA must accompany the claim for reimbursement.

Eyeglasses or Contact Lenses—Both are covered under limited circumstances such as corneal lens removal.

Food, Food Substitutes or Supplements, or Vitamins—Not covered outside of a hospital setting.

Gastric Bypass—To be covered, you must be 100 pounds over ideal body weight and have a co-morbidity or 200 percent of ideal body weight with no co-morbidity.

Genetic Testing—Genetic testing is only covered under certain conditions.

Hearing Aids—Hearing aids are covered under the PFPWD.

Intelligence Testing—Only covered when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.

Marital Therapy and/or Couples

Counseling—Beneficiaries for whom this treatment modality is authorized must have a covered DSM-IV primary diagnosis, and the marital or couples therapy must be medically necessary.

Private Hospital Rooms—Not covered unless ordered for medical reasons, or a semi-private room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room, but will only receive the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.

Smoking Cessation—Not a covered service except for certain TRICARE Prime Remote active duty service members who meet specific criteria.

Weight Reduction—Only covered when psychiatric or psychological evaluations are conducted to assess appropriateness for covered surgical gastric procedures.

Exclusions

The following services are excluded under any circumstance:

- Acupuncture
- Artificial insemination
- Autopsy services or post-mortem examinations
- Care that is not medically or psychologically necessary
- Birth control (non-prescription)
- Camps (such as those for diabetics or obese persons)
- Care or supplies furnished or prescribed by an immediate family member
- Diagnostic admissions
- Experimental or unproven procedures
- Foot care (routine)
- Laser/LASIK/Refractive corneal surgery
- Learning disabilities
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Psychiatric treatment for sexual dysfunction
- Sex changes or sexual inadequacy treatment
- Telephone counseling consultation

Understanding TRICARE Costs and Fees

Review the benefits and coverage charts in the section entitled “What TRICARE Covers” for more information about specific cost-shares and copayments for TRICARE-covered services.

TRICARE Annual Deductible

There is no annual deductible for TRICARE Prime or TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM). (However, there is a deductible if a TRICARE Prime or TPRADFM beneficiary exercises the point-of-service [POS] option.)

TRICARE Extra and TRICARE Standard beneficiaries are required to meet an annual deductible for outpatient services. The deductibles are as follows:

- Active duty family members (ADFM)s E-4 and below: \$50/person or \$100/family per fiscal year
- All retirees and active duty family members E-5 and above: \$150/person or \$300/family per fiscal year

TRICARE Prime Point-of-Service Option

The TRICARE Prime POS option applies to all non-referred, nonemergency services received by TRICARE Prime and TPRADFM beneficiaries. The POS deductible applies only to outpatient services, and the cost-share applies to both inpatient and outpatient services. TRICARE reimbursement is limited to 50 percent of the TRICARE allowable charge. The POS option also applies to prescription drugs. If you take your prescription into a non-network pharmacy, you will pay more. POS cost-sharing and deductible amounts do not apply if you have other health insurance (OHI). The POS deductibles and cost-shares are as follows (for all beneficiary categories):

Deductibles:	\$300 per individual/\$600 per family
Cost-share:	50 percent of the TRICARE allowable charge

Catastrophic Cap Benefit

The catastrophic cap limits your out-of-pocket liability on copayments, cost-shares, and deductibles. The catastrophic cap by beneficiary category is as follows:

- ADFMs using TRICARE Standard—\$1,000 per fiscal year
- All other beneficiaries using TRICARE Standard (retirees, family members of retirees, survivors, former spouses)—\$3,000 per fiscal year
- ADFMs using TRICARE Prime—\$1,000 per fiscal year
- All other beneficiaries using TRICARE Prime (retirees, family members of retirees, survivors, former spouses)—\$3,000 per fiscal year

TRICARE Prime POS option and the Catastrophic Cap

For unauthorized care, the TRICARE Prime POS deductible is \$300 per person and \$600 per family. The beneficiary cost-share is 50 percent of the allowable charges after the deductible.

The TRICARE Prime beneficiary’s out-of-pocket cost while utilizing POS is accrued against the catastrophic cap. However, there is no cap on POS out-of-pocket expenses. The beneficiary cost-share will remain at 50 percent of the TRICARE allowable charge even after the catastrophic cap has been reached.

Other Health Insurance

TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs or plans as identified by the TRICARE Management Activity (TMA). If you have other health insurance (OHI), you are not required to obtain referrals or prior authorizations for covered services, except for adjunctive dental care, the PFPWD, stem cell and organ transplants, and



behavioral health care services. A former spouse covered by an employer-sponsored OHI plan is not eligible for TRICARE.

After OHI has covered its portion of the bill, TRICARE will review your claims to determine if any additional payment should be made. The OHI payment methodology for all primary coverage EXCEPT Medicare is that once your provider has received the full TRICARE allowable charge from any source (including your OHI and our payment), they have received all the money available. Watch your TRICARE explanation of benefits for “Beneficiary Responsibility.” Always submit all claims to TRICARE because deductibles may be applied to your annual catastrophic cap. Your provider

may submit secondary claims for you. If you are submitting a secondary claim, you must include DD Claim Form 2642 (available online at www.triwest.com). Send your itemized bill and a copy of the OHI’s explanation of benefits to:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

Please inform your provider and TriWest if you have OHI so that your benefits can be coordinated and so there is no delay in payment of claims.

Third Party Liability

The Federal Medical Recovery Act allows TRICARE to be reimbursed for its costs of treating you if you are injured in an accident that was caused by someone else. The DD Form 2527 Statement of Personal Injury Third Party Liability Form will be sent to you if a claim is received that appears to have third party liability involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning the form to the appropriate claims processor. The DD Form 2527 is available through the TriWest Web site at www.triwest.com.

TRICARE Explanation of Benefits

A TRICARE explanation of benefits (EOB) is a statement sent to you showing what action has been taken on your TRICARE claims. An EOB is sent to you for your information and files. An EOB is not a bill. After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. You should keep EOBs with your health insurance records for reference.

Your TRICARE Claims

Payment of health care-related claims in a timely manner is important. One of the benefits of being enrolled in TRICARE Prime is that there are virtually no claims for you to file. Your network primary care manager (PCM) will file claims on your behalf, and all TRICARE network providers are required to file claims for beneficiaries using TRICARE Extra. However, beneficiaries choosing TRICARE Standard using non-network providers may be required to file their own claims.

By using the following checklist, you can help to make sure your claims are paid in a timely manner:

- Update DEERS for yourself and/or your family regularly.
- Call your PCM first for all health care needs. In the case of an emergency, go immediately to the emergency room or dial 911 and notify your PCM within 24 hours for potential follow-up care.
- Ensure authorizations and/or referrals have been obtained before receiving care.
- When receiving care, show both your military and TRICARE Prime identification cards.
- If you have other health insurance (OHI), you must follow the OHI rules when receiving services outside of the military treatment facility (MTF), or TRICARE coverage may be restricted or denied.
 - Be sure to follow the OHI rules for authorization.
 - Before seeking care you must contact your OHI plan to obtain any required authorization for non-MTF services, and to help ensure those services are received from an OHI company network provider.
 - Claims for services must be submitted to the OHI plan by you or your provider.
 - After the OHI plan makes payment on the claim, you or your provider may submit a secondary claim to TRICARE, which will determine if an additional payment may be made based on its coverage.
 - For assistance in contacting the OHI plan or filing a secondary claim, call 1-888-TRIWEST (1-888-874-9378).

- See detailed information about OHI in the section entitled “Understanding TRICARE Costs and Fees.”

TRICARE Prime enrollees will receive most medical care from an MTF or network provider. On occasion, you may be referred to a non-network provider if the needed medical care is not available in the network, or you may receive services from a non-network practitioner at a hospital. Some non-network providers are allowed to bill a TRICARE Prime enrollee for amounts over what TRICARE pays (not to exceed the TRICARE allowable charge by 15 percent). This is called “balance billing.” A provider who accepts assignment will file the claim for the enrollee and receive payment directly from TRICARE. They will not balance bill.

In the event you receive a bill or pay for authorized services from a non-network provider, submit a copy of the bill and the following information on the DD Claim Form 2642 or CMS Form 1500. These forms are available on www.triwest.com:

- The sponsor’s name, address, Social Security number, date of birth, and the name of the patient
- The name and address of the provider of service and date(s) of services (if not on the bill)
- A brief explanation of why you needed care, including the diagnosis, if you know it

Where to Send Claims

All claims, including claims for active duty service members, should be sent to the following address:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

The reimbursement you receive, if any, will be consistent with TRICARE coverage provisions. If you need assistance with a claim or have questions, please call TriWest at 1-888-TRIWEST (1-888-874-9378).

Claims for Dual-Eligible Beneficiaries (Medicare and TRICARE)

Wisconsin Physicians Service (WPS) is the claims processor for all claims for beneficiaries who are eligible for both TRICARE and Medicare. Claims are submitted on your behalf by your provider and you will receive an explanation of benefits (EOB) from WPS after the claims processing has been completed. The chart below contains important contact information for you regarding dual-eligible claims.

Claims Submission	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
Appeals	WPS TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490
Program Integrity	WPS TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
Third Party Liability	WPS TRICARE For Life Attn: Third Party Liability P.O. Box 7897 Madison, WI 53707-7897
Refunds	WPS TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
Customer Service	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
Toll-free	1-866-773-0404
Toll-free TDD Telephone	1-866-773-0405
Online	www.tricare4u.com

Submitting Claims While Transitioning to the TRICARE West Region

As the current TRICARE regions transition to the new TRICARE West Region, it is important that you and/or your provider pay careful attention to the dates of service, the current region in which you are receiving care, and the transition dates in order to file with the correct claims processor. Network providers currently in the Health Net provider network should follow Health Net instructions for service dates prior to June 1, 2004. The regions and transition dates are described below.

Washington, Oregon, and Northern Idaho

All non-network claims with dates of service prior to June 1, 2004, should continue to be sent to WPS at the current address until August 31, 2004. On and after September 1, 2004, all claims with dates of service of June 1, 2004, or after should be sent to:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

California, Alaska, and Hawaii

All non-network claims with dates of service prior to July 1, 2004, should continue to be sent to Palmetto Government Benefits Administrators, LLC (PGBA) at the current address until September 30, 2004. On and after October 1, 2004, all claims with dates of service of July 1, 2004, or after should be sent to:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

Central Region

All non-network claims with dates of service prior to October 1, 2004, should continue to be sent to PGBA at the current address until December 31, 2004. On and after January 1, 2005, all claims with dates of service of October 1, 2004, and after should be sent to:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

Network providers currently in the TriWest provider network should send all claims with

service dates prior to October 1, 2004, to PGBA at the current address until April 1, 2005. Beginning April 1, 2005, all claims with service dates prior to October 1, 2004, should be sent to:

West Region Claims
P.O. Box 77028
Madison, WI 53707-7028

The reimbursement you receive, if any, will be consistent with TRICARE coverage provisions. If you need assistance with a claim or have questions, please call TriWest at 1-888-TRIWEST (1-888-874-9378).



Ensuring Customer Satisfaction

Appealing a Decision

An appeal is a dispute with certain payment and/or coverage decisions made by TRICARE. There are two types of appeals: a factual denial (i.e. non-covered service) and an appeal of a denial of services based upon medical necessity. You have the right to appeal the decisions TRICARE makes regarding the payment of claims. Additionally, there is a separate mechanism for appealing the denial for authorization of services based upon a medical necessity review.

Appeal of a Claim

This appeal is based on the denial of benefits during claims processing. To appeal a claims decision, submit your appeal in writing to:

TriWest Healthcare Alliance
Claims Appeals
P.O. Box 86036
Phoenix, AZ 85080

You must file your appeal within 90 days of the date on the explanation of benefits (EOB). Be sure to include a copy of the EOB along with any materials you feel will explain your reasons for the appeal.

You may appeal the payment of a claim under the point-of-service (POS) option if you believe the care was an emergency. In this case, mark your appeal "POS Claims Appeals" and send to:

TriWest Healthcare Alliance
Attn.: POS Claims Appeals
P.O. Box 42049
Phoenix, AZ 85080

Appeal of a Medical Decision

When a service request is denied for lack of medical necessity, you will receive written notification of the decision, including your appeal rights. These services may include a referral, a procedure or continued stay in a

medical facility. This type of appeal is based upon medical necessity and follows a different process from a claims appeal. There are two levels of appeal: a reconsideration of a denial of an authorization and an appeal of a reconsideration. When TriWest denies services based on a medical necessity review, the provider and beneficiary are automatically notified in writing. The notification includes an explanation of what was denied and the reasoning behind that decision. You can request an appeal of the denial of a care approval or reconsideration by sending your request in writing to:

TriWest Healthcare Alliance
Attn.: Reconsideration Unit
P.O. Box 42049
Phoenix, AZ 85080

Grievances

A grievance is a written formal complaint about service or care. You may file a grievance about such items as quality of care, quality and availability of service, timeliness of services, appropriateness of care, and inappropriate behavior on the part of a health care provider.

It is best to resolve your complaint with your health care provider. If the provider is unable to help you, you may submit your grievance in writing to TriWest for resolution. All grievances should be addressed to:

TriWest Healthcare Alliance
Attn.: Customer Relations Dept.
P.O. Box 42049
Phoenix, AZ 85080

You will receive an interim written response within 30 days if the grievance is not resolved, and a final written notification of the results within 60 days.



Assistance with Collection Activities

Debt Collection Assistance Officers (DCAOs) are located at the TRICARE Regional Office–West and each military treatment facility (MTF) to assist you in resolving health care collection-related issues. Questions about billing should be addressed to TriWest.

You must bring or submit documentation associated with a collection action or adverse credit rating to the DCAO for assistance. This includes debt collection letters, explanations of benefits statements, and medical/dental bills from providers. The more information you can provide, the faster it will be to determine the cause of the problem. The DCAO will research your claim, provide you with a written resolution of your collection problem, and inform the collection agency that action is being taken to resolve the issue.

DCAOs cannot provide legal advice or fix your credit rating, but they can help you through the debt collection process by providing

documentation for the collection or credit-reporting agency in explaining the circumstances relating to the debt. To find a DCAO near you, visit the DCAO directory online at www.tricare.osd.mil/DCAO.

Fraud and Abuse

Anyone can identify potential fraud and abuse. Please be alert to anything that “doesn’t look right.” Call 1-888-584-9378 or fax 1-602-564-2458 to anonymously report suspected fraud and/or abuse and give as much information as possible. Types of activities that should be reported include:

- A provider billing for services when services were not rendered
- Services billed do not match the services rendered
- A provider waiving copayments or deductibles
- Someone you know is not TRICARE eligible but is receiving benefits

For Information and Assistance

Regional Information Resources

Through the enhanced interactive customer service features of TriWest's Web site, www.triwest.com, and TriWest's Interactive Voice Response (IVR) system, you will be able to conduct most of your business with TriWest from your personal computer or telephone.

TriWest Web Site www.triwest.com

All TRICARE beneficiaries have access to the most current TRICARE information through TriWest's Web site. You will be able to conduct most of your business with TriWest without leaving home. You will be able to:

- Determine the status of a claim, receive information about the payment of a previously processed claim, and obtain a duplicate explanation of benefits (EOB) for claims that have been processed
- Verify your eligibility or eligibility for a family member by checking the Defense Enrollment Eligibility Reporting System (DEERS)
- Check the current dollar amounts applied toward your out-of-pocket expense limits
- Learn about your TRICARE benefits by reviewing a list of frequently asked questions, utilizing a search engine, or by submitting a question electronically to TriWest
- Locate a network provider
- Visit your local military treatment facility (MTF) online (if the MTF has a Web page)
- Receive the latest regional updates from the TRICARE West Regional Office staff

You will also find a monthly feature of special topics: weekly TRICARE program updates; provider directory updates; the latest TRICARE and TriWest news; a new Healthy Living section; review the rules of Other Health Insurance (OHI), and keep your records up-to-date; find contact information for your local military treatment facility; receive the latest regional updates from the TRICARE Regional Office—West staff.

Interactive Voice Response System 1-888-TRIWEST (1-888-874-9378)

When you dial 1-888-TRIWEST (1-888-874-9378), TriWest's Interactive Voice Response (IVR) System will quickly route your requests and inquiries to the most appropriate customer service representative and will offer an automated self-service option for accessing recorded routine information. You will speak your menu requests rather than using the telephone keypad. The convenient, voice-activated IVR system will be available around the clock, 24 hours a day, seven days a week. You will be able to access personalized information regarding eligibility; benefits and health care plan guidelines; claim status; and fee payments, cost-shares, and deductibles. If you prefer, you will also be able to speak with a customer service representative.

TriWest's customer service representatives are available Monday–Friday 8 a.m. to 6 p.m. in all West Region time zones to assist you.



National Information Resources

TRICARE Web Site **www.tricare.osd.mil**

You can consult TRICARE's trusted online resource for the most up-to-date information about TRICARE. Learn about TRICARE program options, policies and guidance, and the latest news and events.

TRICARE Online **www.tricareonline.com**

The Department of Defense's (DoD's) Internet portal to TRICARE and health care information, TRICARE Online is available to all TRICARE beneficiaries. Registered users can even book appointments online.

TRICARE Information Service **1-888-363-CARE (1-888-363-2273)**

Customer service representatives are available Monday–Friday (except federal holidays) from 8 a.m. to 8 p.m. Eastern Time to answer your questions. An interactive voice response (IVR) feature, available 24 hours a day, seven days a week, works with the TRICARE Information Service and offers you access to commonly requested TRICARE eligibility information. It also offers assistance finding the appropriate partner call center for specific issues. With the TRICARE IVR, callers may request TRICARE information by saying the number of the option they wish to hear about or by using a touch-tone telephone keypad.

Beneficiary Tools

Common TRICARE Acronyms

ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
BCAC	Beneficiary Counseling and Assistance Coordinator
CHCBP	Continued Health Care Benefit Program
DCAO	Debt Collections Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DSO	Defense Manpower Data Center (DMDC) Support Office
EOB	Explanation of Benefits
HCF	Health Care Finder
HMHS	Humana Military Healthcare Services
MHS	Military Health System
MTF	Military Treatment Facility
NOAA	National Oceanic and Atmospheric Administration
OHI	Other Health Insurance
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
PGBA	PGBA, LLC
PHS	Public Health Service
POS	Point-of-Service
RC	Reserve Component
SPOC	Service Point of Contact
TAMP	Transitional Assistance Management Program
TDP	TRICARE Dental Program
TFL	TRICARE For Life
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRO	TRICARE Regional Office

TRRx	TRICARE Retail Pharmacy Program
TSC	TRICARE Service Center
UCCI	United Concordia Companies, Inc.
USFHP	Uniformed Services Family Health Plan
USPHS	United States Public Health Service
WPS	Wisconsin Physicians Service



Glossary of Terms

Allowable Charge, also TRICARE Allowable Charge

The term “allowable charge” is the maximum amount TRICARE will authorize for medical and other services furnished in an inpatient or outpatient setting. The allowable charge is normally the lowest of the actual billed charge or the allowable charge. For example, if the allowable charge for a service is \$90 and the billed charge is \$50, TRICARE will pay \$50 (actual billed charge); if the billed charge is \$100, TRICARE will pay \$90 (the allowable charge). In the case of inpatient hospital payments, the diagnosis-related group (DRG) is the TRICARE allowable charge of the billed amount regardless.

Authorized Provider

An authorized provider is a hospital or institutional provider, a physician or other individual professional provider, or other provider of services meeting specific educational, licensing, and other requirements. Authorized providers are not necessarily network providers. TRICARE will share costs if a beneficiary sees a provider of this type.

Balance Billing

A term used to describe when a provider bills a beneficiary for the rest of the charges. A beneficiary cannot be billed for the remainder or “balance” of the provider charges, after TRICARE (and other health insurance) has paid everything it’s going to pay. A beneficiary is not legally responsible for amounts above 15 percent of the TRICARE allowable charge, even if the provider is not network and does not accept assignment of benefits. Network providers are prohibited from balance billing.

Beneficiary

A person who is eligible for TRICARE benefits. Beneficiaries include active duty service members, active duty family members (ADFMs), retired service members and their families. Family members include

spouses and unmarried natural or stepchildren up to the age of 21 (or 23 if full-time students at accredited institutions of learning). Other beneficiary categories are listed in the section entitled “Eligibility for TRICARE.”

Beneficiary Counseling and Assistance Coordinators (BCACs)

Persons at military treatment facilities (MTFs) who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. BCACs were previously known as Health Benefits Advisors or HBAs.

Catastrophic Cap

The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (October 1–September 30). The catastrophic cap for active duty families is \$1,000, and the catastrophic cap for all other TRICARE eligible families is \$3,000.

Certified Provider

A certified provider is one that meets all the requirements to be a TRICARE-authorized provider and has been “certified” to provide services to TRICARE beneficiaries. “Authorized” and “certified” are interchangeable terms.

Copayment

The fixed amount a TRICARE Prime* enrollee will pay for care in the civilian provider network. Active duty service members and active duty family members are not required to pay copayments for services received from a network provider under TRICARE Prime.

Cost-Share

The percentage of the allowable charges a beneficiary will pay under TRICARE Extra and TRICARE Standard. The cost-share depends on the sponsor’s status—active duty or retired.

**Includes TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members.*

Deductible

The annual amount a TRICARE Extra or TRICARE Standard beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs. TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries do not have an annual deductible, unless they are utilizing their point-of-service (POS) option.

Enrollee

A TRICARE-eligible beneficiary who has elected to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members.

Explanation of Benefits (EOB)

A statement sent to beneficiaries showing that claims were processed and the amount paid to providers. If denied, an explanation of denial is provided.

Health Care Finder (HCF)

Representatives who help locate TRICARE providers and applicable community, state, and federal health care resources for beneficiaries who require benefits and services beyond TRICARE.

Military Treatment Facility (MTF)

A medical facility operated by the military that may provide inpatient and/or ambulatory care to eligible TRICARE beneficiaries. MTF capabilities vary from limited acute care clinics to teaching and tertiary care medical centers.

Network Provider

A network provider is one who serves TRICARE beneficiaries by agreement with your region's contractor as a member of the TRICARE Prime network or any other preferred provider network or by any other contractual agreement. A network provider accepts the negotiated rate as payment in full for services rendered.

Nonavailability Statement (NAS)

A certification from an MTF that a specific health care service or procedure cannot be provided.

Non-network Provider

A non-network provider is one who has no contractual relationship to provide care to TRICARE beneficiaries, but is authorized to provide care to TRICARE beneficiaries. A non-network provider must be authorized. There are two types of non-network providers—"participating" and "non-participating."

Nonparticipating Provider

A nonparticipating provider is an authorized hospital, institutional provider, physician, or other provider that furnishes medical services (or supplies) to TRICARE beneficiaries, but who has not signed a contract with your regional contractor and does not agree to "accept assignment." A nonparticipating provider may balance bill.

Other Health Insurance (OHI)

Any non-TRICARE health insurance that is not considered a supplement. This insurance is acquired through an employer, entitlement program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs or plans as identified by TRICARE Management Activity (TMA).

Participating Provider

Providers who participate in TRICARE, also called "accepting assignment," and agree to accept the TRICARE-determined allowable cost or charge as the total charge for services—also known as the TRICARE allowable charge as the full fee for care. In the case of network providers, the negotiated rate is considered the full fee for care. Non-network, individual providers may participate on a case-by-case basis. Providers may seek applicable copayments, cost-shares, and deductibles from the beneficiary.

Hospitals that participate in Medicare must, by law, also participate in TRICARE for inpatient care. For outpatient care, they may or may not participate.

Point of Service (POS)

An option that allows a TRICARE Prime beneficiary to obtain medically necessary services—inside or outside the network—from someone other than his or her primary care manager, without first obtaining a referral or authorization. Utilizing the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary.

Pre-Authorization

See the definition for Prior Authorization.

Primary Care Manager (PCM)

A TRICARE civilian network provider or military treatment facility (MTF) provider who provides primary care services to TRICARE beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF commander or his or her designated appointee. To the extent consistent with governing state rules and regulations, PCMs can include internal medicine physicians, family practitioners, pediatricians, general practitioners, obstetricians, gynecologists, physician assistants, nurse practitioners, or certified nurse midwives.

Note: TRICARE Prime Remote beneficiaries may choose a TRICARE authorized provider if a network provider is not available.

Prime Service Area

Formerly was called catchment area defined to be within a 40-mile radius (determined by ZIP code) of a military treatment facility (MTF). It now also includes areas containing a high concentration of TRICARE beneficiaries and who are not within the catchment area of an MTF. TriWest is required to offer TRICARE Prime in each prime service area.

Prior Authorization

A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures, or admissions. Prior authorizations must be obtained prior to services being rendered or within 24 hours of an admission.

Referral

The process by which a primary care manager (PCM) refers a TRICARE Prime beneficiary to another professional or ancillary provider for specialized medical services, prior to those services being rendered.

Reserve Component (RC)

The RC includes the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.

Split Enrollment

Refers to multiple family members enrolled in TRICARE Prime in different TRICARE regions.

Sponsor

The active duty service member (ADSM) or retiree through whom family members are eligible for TRICARE.

Supplemental Insurance

Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

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